aleracare
advanced specialty pharmacy

Pulmonary
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (ID & Group #) ◯ Current Medications ◯ History/Progress Notes

Diagnosis

ICD-10 Codes: ◯ J82.83 Eosinophilic Asthma ◯ J44.9 COPD ◯ Other: _____

Medication	Dose/Strength	Directions for Use	Qty	Refills
◯ **ACTEMRA® PFS** (tocilizumab) ◯ **ACTEMRA ACTPEN®** (tocilizumab)	◯ 162 MG/0.9 ML	◯ Inject 162 mg subq every week		
◯ **DUPIXENT®** (dupilumab) ◯ **PFS** ◯ **Pen**	◯ 200 mg/1.14 mL ◯ 300 mg/2mL	◯ **Initial:** Inject 400 mg subq x 1 ◯ **Maintenance:** Inject 200 mg subq every other week OR ◯ **Initial:** Inject 600 mg subq x 1 ◯ **Maintenance:** Inject 300 mg subq every other week		
◯ **FASENRA®** (benralizumab) ◯ **PFS** ◯ **Pen**	◯ 30 mg/mL	◯ **Initial:** Inject 30 mg subq every 4 weeks x 3 doses ◯ **Maintenance:** Inject 30 mg subq every 8 weeks		
◯ **NUCALA®** (mepolizumab) ◯ **PFS** ◯ **Pen**	◯ 100 mg/mL	◯ Inject 100 mg subq every 4 weeks		
◯ **TEZSPIRE®** (tezepelumab) ◯ **PFS** ◯ **Pen**	◯ 210 mg/1.91 mL	◯ Inject 210 mg subq every 4 weeks		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____